

MDR Tracking Number: M5-04-4090-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 07-30-04.

The requestor withdrew CPT code 97112 for date of service 08-01-03, therefore will not be reviewed.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. The IRO determined that the therapeutic procedures, manual therapy and neuromuscular re-education from 09-05-03 through 10-03-03 **were** medically necessary. The IRO determined that the remainder of services **were not** medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee. The respondent raised no other reasons for denying reimbursement for the above listed services.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 09-05-03 through 10-03-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 3rd day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

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NOTICE OF INDEPENDENT REVIEW DECISION

November 16, 2004

Re: IRO Case # M5-04-4090

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical medicine and Rehabilitation, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits

3. M.D. initial consultation note 2/20/03
4. Radiological reports of cervical and lumbar spine, including flexion and extension views 2/20/03
5. EMG/NCS report 3/10/03
6. M.D. new patient evaluation 2/27/03
7. Report CT scan of the lumbar spine 4/7/03
8. IMEs 4/30/03, 11/21/03
9. DDE 5/13/03
10. M.D. initial medical report 5/20/03
11. D.C. initial evaluation 6/20/03, and subsequent evaluation 7/22/03
12. Evaluation 8/5/03
13. Physical therapy notes
14. Pain management M.D. note 9/11/03
15. Operative reports 9/24/03, 10/15/03
16. Follow up notes 10/2/03, 10/23/03
17. FCE reports 11/12/03, 3/9/04
18. Work hardening evaluation 11/21/03
19. Report of initial consultation 12/29/03
20. Analysis 1/19/04
21. Subsequent medical reports 2/26/04, 3/30/04
22. MRI lumbar spine report 3/8/04
23. Work capacity evaluation 4/7/04

History

The patient was injured in ____ when she slipped and fell, landing on her buttocks. She was seen by an M.D. on 2/20/03 with pain in her low back that radiated into her legs. She also complained of some urinary incontinence. She was diagnosed with acute lumbar strain and post-traumatic urinary incontinence. She was started on medications for her incontinence as well as pain medications and muscle relaxers. The patient was also started on physical therapy. A lumbar MRI and x-rays were thought to be normal. EMG/NCS on 3/10/03 did not show any abnormalities. On 3/27/03 the patient had an orthopedic spine consultation, and her neurologic examination was normal. Epidural steroid injections were recommended. Surgery was not recommended. A CT scan of the lumbar spine on 4/7/03 showed a shallow, 2mm right paracentral posterior disk bulge at L4-5. The remainder of the CT scan was unremarkable. The treating M.D. evaluated the patient on 5/20/03, and the patient began chiropractic treatment on 6/20/03. The treatment plan included treadmill, stretching, neuromuscular reeducation, therapeutic exercises and passive modalities. The patient was evaluated on 8/5/03 and epidural steroid injections were recommended, as well as studies to evaluate bladder changes. On a 11/12/03 FCE the patient demonstrated a medium physical demand level performance. A heavy physical demand level is required for the patient's job. The patient underwent work hardening evaluation on 11/21/03.

Requested Service(s)

Therapeutic procedures, manual therapy technique, office visits, neuromuscular reeducation, electrical stimulation, ultrasound, telephone call physician to patient 8/1/03 – 12/12/03

Decision

I disagree with the carrier's decision to deny the requested therapeutic procedures, manual therapy technique and neuromuscular reeducation 9/5/03 – 10/3/03. I agree with the decision to deny the remainder of the services.

Rationale

The patient had months of physical therapy prior to the dates in dispute without documented benefit. Nevertheless, physical therapy would be medically appropriate for four weeks while the patient was receiving epidural steroid injections. The patient was treated with epidural steroid injections on 9/30/03, 9/24/03, and 10/15/03. Four weeks of physical therapy during the period of her procedures is a medically necessary adjunct to her treatment. No more than one hour of physical therapy, three times per week would be medically necessary. After four weeks, the patient could then continue with a home exercise program as she continued on to a third injection.

Except as indicated above, it would not be medically indicated to continue physical therapy after several months of physical therapy without documented benefit. E & M services would not be medically necessary, as they are performed as a part of each physical therapy session

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.